MEDAVIE BLUE CROSS™

INDIVIDUAL HOSPITAL CASH CLAIM FORM

THIS FORM CAN BE COMPLETED FOR ELIGIBLE MEMBERS WHO HAVE BEEN CONFINED TO A HOSPITAL IN CANADA ON AN INPATIENT BASIS UNDERGOING ACTIVE TREATMENT WHILE INSURED.

MEMBER INFORMATION - To be completed by member or patient

ID Number: _____ Policy Number: _____ Date of Birth (DD/MM/YYYY): _____

Last Name: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone Number: _____ Work Telephone Number: _____

Has your mailing address changed since your last claim? ○ Yes ○ No

If yes, signature of member is required for validation: _____

PATIENT INFORMATION - To be completed by member or patient

Patient Name: _____ If dependent is over the age 21: ○ Special Dependent ○ Full-time Student

Date of Birth (DD/MM/YYYY): _____ If Student, School Name: _____

Address: _____

Relationship to Member: ○ Self ○ Spouse ○ Dependent Telephone Number: _____

MEMBER STATEMENT

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511.

Signature: _____ Date (DD/MM/YYYY): _____

ATTENDING PHYSICIAN'S STATEMENT (Any charge for completing this form is the patient's responsibility)

Date of Admission*: _____ Date of Discharge*: _____

Name of Hospital: _____ Telephone No.: _____

Address: _____ Postal Code: _____

Was hospitalization due to: ○ an accident ○ sickness ○ or maternity?

Was the patient receiving active treatment? ○ Yes ○ No

If Yes, period of treatment: From: _____ To _____

Diagnosis: _____

When did this patient first show any symptoms related to this diagnosis? (DD/MM/YYYY): _____

***Please attach a copy of the discharge summary for the admission and discharge dates indicated above.**

Name of attending physician: _____ Telephone No.: _____
(please print)

Physician Signature: _____ Date: _____

MEDAVIE BLUE CROSS ADDRESS

Atlantic Provinces
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